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8 **BEFORE THE**  
**BOARD OF REGISTERED NURSING**  
9 **DEPARTMENT OF CONSUMER AFFAIRS**  
10 **STATE OF CALIFORNIA**

11 In the Matter of the First Amended Accusation  
Against:

Case No. 2009-28

12 MAGDA GONZALEZ  
13 a.k.a. MAGDA C. NERCISSANTZ  
a.k.a. MAGDALEN NERCISSANTZ  
14 a.k.a. MAGDALENA NERCISSANTZ  
a.k.a. MAGDALENA MANASSERIAN  
15 5594 North Berkeley Street  
San Bernardino, CA 92407

**FIRST**  
**AMENDED**  
**ACCUSATION**

16 Registered Nurse License No. 375784

17  
18 Respondent.

19 Complainant alleges:

20 **PARTIES**

21 1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this First Amended  
22 Accusation solely in her official capacity as the Executive Officer of the Board of Registered  
23 Nursing, Department of Consumer Affairs (Board).

24 2. On or about August 31, 1984, the Board issued Registered Nurse  
25 License Number 375784 to MAGDA GONZALEZ a.k.a. MAGDA C. NERCISSANTZ a.k.a.  
26 MAGDALEN NERCISSANTZ a.k.a. MAGDALENA NERCISSANTZ a.k.a. MAGDALENA  
27 MANASSERIAN (Respondent). The Registered Nurse License will expire on August 31, 2010  
28

1 unless renewed.

2 **JURISDICTION**

3 3. On or about July 31, 2008, the original Accusation was filed in this matter,  
4 and duly served to Respondent, who filed her timely Notice of Defense. This First Amended  
5 Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer  
6 Affairs, under the authority of the following laws. All section references are to the Business and  
7 Professions Code unless otherwise indicated.

8 **STATUTORY PROVISIONS**

9 4. Section 2750 of the Business and Professions Code (Code) provides, in  
10 pertinent part, that the Board may discipline any licensee, including a licensee holding a  
11 temporary or an inactive license, for any reason provided in Article 3 (commencing with section  
12 2750) of the Nursing Practice Act.

13 5. Section 2764 of the Code provides, in pertinent part, that the expiration of  
14 a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding  
15 against the licensee or to render a decision imposing discipline on the license. Under section  
16 2811(b) of the Code, the Board may renew an expired license at any time within eight years after  
17 the expiration.

18 6. Section 2761 of the Code states in pertinent part:

19 "The board may take disciplinary action against a certified or licensed nurse or  
20 deny an application for a certificate or license for any of the following:

21 "(a) Unprofessional conduct, which includes, but is not limited to, the following:

22 "(1) Incompetence, or gross negligence in carrying out usual certified or licensed  
23 nursing functions.

24 . . . .

25 "(d) Violating or attempting to violate, directly or indirectly, or assisting in or  
26 abetting the violating of, or conspiring to violate any provision or term of this chapter [the  
27 Nursing Practice Act] or regulations adopted pursuant to it.

28 7. Section 2762 states:

1 "In addition to other acts constituting unprofessional conduct within the meaning  
2 of this chapter [chapter 6, commencing with section 2700], it is unprofessional conduct for a  
3 person licensed under this chapter to do any of the following:

4 "(a) Obtain or possess in violation of law, or prescribe, or except as directed by a  
5 licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish  
6 or administer to another, any controlled substance as defined in Division 10 (commencing with  
7 Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as  
8 defined in Section 4022.

9 "(b) Use any controlled substance as defined in Division 10 (commencing with  
10 Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as  
11 defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or  
12 injurious to himself or herself, any other person, or the public or to the extent that such use  
13 impairs his or her ability to conduct with safety to the public the practice authorized by his or her  
14 license.

15 . . . .

16 "(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible  
17 entries in any hospital, patient, or other record pertaining to the substances described in  
18 subdivision (a) of this section."

19 8. Section 2764 states:

20 "The lapsing or suspension of a license by operation of law or by order or decision  
21 of the board or a court of law, or the voluntary suspension of a license by a licentiate shall not  
22 deprive the board of jurisdiction to proceed with any investigation of or disciplinary proceeding  
23 against such license, or to render a decision suspending or revoking such license."

24 9. Health and Safety Code section 11170 states that no person shall prescribe,  
25 administer, or furnish a controlled substance for himself.

26 10. Health and Safety Code section 11171 states that no person shall prescribe,  
27 administer, or furnish a controlled substance except under the conditions and in the manner  
28 provided by the Uniform Controlled Substances Act.

11. Health and Safety Code section 11173 states:

“(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

“(b) No person shall make a false statement in any prescription, order, report, or record, required by this division.”

....

12. Health and Safety Code section 11350 states:

“Except as otherwise provided in this division, every person who possesses (1) any controlled substance specified in subdivision (b) or (c), or paragraph (1) of subdivision (f) of Section 11054, specified in paragraph (14), (15), or (20) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055, or specified in subdivision (h) of Section 11056, or (2) any controlled substance classified in Schedule III, IV, or V which is a narcotic drug, unless upon the written prescription of a physician, dentist, podiatrist, or veterinarian licensed to practice in this state, shall be punished by imprisonment in the state prison.”

13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

14. Section 118, subdivision (b), of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

### DEFINITIONS

15. “Demerol,” is a brand of meperidine hydrochloride, a derivative of pethidine. It is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(17) and is categorized as a “dangerous drug” pursuant to Business and Professions Code section 4022.

16. “Darvocet” is a combination drug containing propoxyphene napsylate and

1 acetaminophen, is a Schedule IV controlled substance as designated by Health and Safety Code  
2 section 11057(c)(2) and is categorized as a "dangerous drug" pursuant to Business and  
3 Professions Code section 4022.

4 17. "Vistaril" is a brand name for the drug Hydroxyzine, an antihistamine used  
5 to relieve itching and allergic reactions, and conditions that may result in anxiety and tension.

6 18. "Pyxis" is a computerized automated medication system with  
7 operates similarly to an automated teller machine at a bank. Medications can be withdrawn from  
8 the Pyxis machines only by an authorized staff person using his or her own personalized access  
9 code. The Pyxis machine makes a record of the medication and dose, date and time it was  
10 withdrawn, the user identification, and the patient for whom it was withdrawn.

11 **FIRST CAUSE FOR DISCIPLINE**

12 **COMMUNITY HOSPITAL OF SAN BERNARDINO**

13 **(Obtaining Controlled Substances by Fraud, Deceit, Misrepresentation or Subterfuge )**

14 19. Respondent's license is subject to disciplinary action under Business and  
15 Professions Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as  
16 defined in Business and Professions Code, section 2762, subdivisions (a) and (b), for violating  
17 Health and Safety Code sections 11170, 11171, and 11173, subdivisions (a) and/or (b) and/or (c)  
18 in that while on duty as a registered nurse at Community Hospital of San Bernardino on and prior  
19 to April 22, 2003, Respondent obtained, possessed, and self-administered controlled substances  
20 and dangerous drugs, by use of fraud, deceit, misrepresentation or subterfuge as follows:

21 A. By her own admission, on or about April 22, 2003, while on duty as a  
22 registered nurse at the Community Hospital of San Bernardino, Labor and Delivery Unit,  
23 Respondent removed a quantity of Demerol from the hospital's Pyxis system and administered  
24 the drug to herself.

25 B. By her own admission, Respondent diverted a large amount of Demerol  
26 from Community Hospital of San Bernardino prior to "being caught" in April of 2003.

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1 found to be in possession of completed TPOS forms for three patients. None of the forms had  
2 been placed in the patient's chart, co-signed by the ordering physician, or otherwise processed in  
3 accord with standard practice and policies at QV.

4 E. Investigators reviewing CSAR documents during Respondent's shifts in  
5 weeks prior to her suspension noted that records for several patients who did not receive  
6 medication at any other time during their hospitalization at QV, showed administration of  
7 Demerol by Respondent during her shift. Investigators also noted numerous irregularities with  
8 telephonic prescription orders for Demerol recorded by Respondent.

9 F. Respondent falsified QV Telephone Physician Order Sheets, and/or  
10 falsified patient records, and/or made written and/or verbal misrepresentations all to facilitate  
11 and/or conceal her diversion of the drugs Demerol and/or Vistaril in the following instances:

12 1. FALSE TELEPHONIC ORDER: **PATIENT MR599140**

13 (a) On December 28, 2006, at the time of her suspension, Respondent  
14 was found to be in possession of a completed original telephonic prescription form dated  
15 December 25, 2006 at 0930, for Patient MR599140 allegedly from *Dr. B. Nguyen* for  
16 "Demerol 50mg IMx1 now give with Vistaril 25MG IMx1 now for moderate pain."

17 (b) This order was falsified by Respondent. *Dr. Nguyen* expressly  
18 denied giving an order for either medication when contacted by a nursing supervisor on or  
19 about December 28, 2006.

20 (c) The order was not processed in compliance with standard practice  
21 and policies at QV.

22 (d) Respondent charted alleged administration of Demerol to the  
23 patient in medical administration records.

24 2. FALSE TELEPHONIC ORDER(S): **PATIENT MR528432**

25 (a) On December 28, 2006 at 0800, Respondent wrote a telephonic  
26 order allegedly for Patient MR528432, a 78 year old male, from *Dr. Makandura* for  
27 "Demerol 50mg Q (every) 4hours for moderate severe pain", along with .25 of the drug  
28 Vistaril as needed.

1 (b) Three (3) hours later, at 1100, Respondent wrote a second  
2 telephonic order allegedly from *Dr. Makandura* for Patient MR 528432 for identical  
3 medications "Demerol 50mg Q4hours for moderate severe pain", along with .25 mg of  
4 the drug Vistaril as needed.

5 (c) These orders were falsified by Respondent.

6 (1) *Dr. Makandura* denied giving either order when contacted by a  
7 nursing supervisor on or about December 28, 2006. He expressly stated that he  
8 had ordered Ativan (a non-narcotic pain medication) for the patient, not Demerol  
9 or Vistaril.

10 (2) Patient records indicate that Patient MR528432 did not receive  
11 narcotic analgesics at any time during his stay at QV, apart from alleged  
12 administration of Demerol by Respondent.

13 3. MISREPRESENTATION: **PATIENT MR750373**

14 (a) On December 18, 2006 at 1115 Respondent wrote a telephonic  
15 physician's order for Demerol 25mg IMx 1 dose.

16 (b) In Nursing Notes for December 18, 2006 at 1100 Respondent  
17 noted that the patient was complaining of pain but "refusing to take Darvocet; states  
18 Darvocet does not work for him."

19 (c) Respondent's report of the patient's refusal of the Darvocet was  
20 false and a misrepresentation about the patient's condition:

21 (1) The patient denied that he had any problems with pain management during  
22 his stay at QV when interviewed by a nursing supervisor on January 2, 2007. He stated  
23 that he had experienced good relief from the Darvocet, and had never received nor  
24 requested other pain medications.

25 (2) The patient had been receiving Darvocet for pain several days prior to  
26 Respondent's entries, and continued to receive it afterward.

27 (d) Respondent charted alleged administration of Demerol to the  
28 patient in medical administration records.

1                                   4.       **MISREPRESENTATION : PATIENT MR438777**

2                                   (a)       On December 14, 2006 at 0710 Respondent wrote a telephonic  
3 physician's orders for patient MR 438777 from *Dr. Jandial* to discontinue Morphine and  
4 substitute "Demerol 75 mg IMQ6 (intramuscular every 6) hours for pain" along with  
5 "Vistaril 50MG IMQ6 hours for pain. The order included the notation "give one dose  
6 now."

7                                   (b)       In Nursing Notes, Respondent documented the patient's purported  
8 complaint of an itchy throat caused by the Morphine; and her advise to the physician of  
9 same.

10                                  (c)       On December 15, 2006 Respondent wrote a second telephonic  
11 physician's orders increasing the frequency of the Demerol 75 mg to IMQ4  
12 (intramuscular every 4) hours.

13                                  (d)       Respondent's report of a patient allergy to morphine was false and  
14 a misrepresentation of the patient's condition.

15                                  (1)       The patient denied that she had experienced an itchy throat from  
16 the morphine, and denied any allergy to Morphine when contacted by a nursing  
17 supervisor on or about December 28, 2006.

18                                  (2)       Despite her entries documenting the patient's purported complaints  
19 of allergy symptoms caused by the Morphine, Respondent did not add 'Morphine'  
20 to the allergy list for the patient.

21                                  (e)       Respondent charted alleged administration of Demerol to the  
22 patient in medical administration records six times - on December 14, 2006 at 1305 and  
23 1859, and December 15, 2006 at 0730, 1120, 1500, and 1859.

24                                  5.       **FALSE TELEPHONIC ORDER: PATIENT MR476510**

25                                  (a)       At the time of her suspension on December 28, 2006 Respondent,  
26 was in possession of a completed original telephonic prescription order dated two weeks  
27 earlier - on December 14, 2006 at 0715, for patient MR47610, a 25 year old female, from  
28 *Dr. Jandial* for "Demerol 50mg IMx1 now give with Vistaril 25MG IMx1 now for

1 moderate pain”.

2 (b) The order was not processed in compliance with standard practice  
3 and policies at QV. It was not co-signed by the ordering physician.

4 (c) Contemporaneous nursing notes by Respondent and others for  
5 December 14, 2006 repeatedly describe the patient as in “no distress” after her arrival on  
6 the Unit.

7 (d) Respondent recorded in Nursing Notes that *Dr. Jandial* was on the  
8 floor visiting the patient (described as “resting in no distress”) at 0830 the morning of  
9 December 14, 2006, making an unsigned telephonic order unlikely.

10 (e) Respondent charted alleged administration of Demerol 50 mg to  
11 the patient twice by injection the morning of December 14, 2006 - once at 0832 and again  
12 at 1110.

### 13 **THIRD CAUSE FOR DISCIPLINE**

#### 14 **CENTRAL VALLEY MEDICAL CENTER - QUEEN OF THE VALLEY FACILITY**

#### 15 **(Falsified Hospital Records)**

16 21. Respondent’s license is subject to disciplinary action under Business and  
17 Professions Code section 2761, subdivision (a) and (d), on the grounds of unprofessional  
18 conduct, as defined in Business and Professions Code, section 2762, subdivision (e), for violating  
19 Health and Safety Code sections 11350, subdivision (a) and 11173, subdivisions (a) and (b), in  
20 that while employed as a registered nurse at Central Valley Medical Center’s Queen of the Valley  
21 Hospital (“QV”) approximately between October 1, 2006 and December 28, 2006 Respondent  
22 falsified, made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and  
23 patient records pertaining to controlled substances and dangerous drugs as described in paragraph  
24 20 above. Complainant refers to, and by this reference incorporates all allegations of paragraph  
25 20 as though set forth fully.

### 26 **FOURTH CAUSE FOR DISCIPLINE**

#### 27 **(Use of Controlled Substance to the Extent Than Use Impairs Safety)**

28 22. Respondent’s license is subject to disciplinary action under Business and

1 Professions Code section 2762, subdivision (b), on the grounds of unprofessional conduct, in  
2 that, on multiple occasions, Respondent has used controlled substances to an extent or in a  
3 manner dangerous or injurious to herself or any other person or the public, or to the extent that  
4 such use impairs her ability to conduct with safety the practice authorized by her license, by  
5 reason of the following facts:

6           A.     By her own admission, between 1999 and 2003, Respondent engaged in  
7 habitual abuse of drugs and alcohol.

8           B.     Community Hospital of San Bernardino - 2003  
9                   As previously alleged at paragraph 19 above, by her own admission, on or  
10 about April 22, 2003, while on duty as a registry nurse at the Community Hospital of San  
11 Bernardino, Labor and Delivery Unit, Respondent removed Demerol from the Pyxis medication  
12 system and administered the drug to herself. By her own admission, while employed as a  
13 registered nurse at the hospital, Respondent diverted a large amount of Demerol prior to 'getting  
14 caught' in April of 2003.

15           C.     Respondent sought treatment for drug and alcohol addiction in Summer of  
16 2003, enrolling in the Board's *Diversion* Program, and accomplished a period of sobriety.

17           D.     Redlands Community Hospital - 2005  
18                   On or about August 12, 2005, while working as a registered nurse at  
19 Redlands Community Hospital, in the city of Redlands, CA, pursuant to routine drug screening  
20 required as a condition of her employment, Respondent tested positive for meperidine (opiates),  
21 resulting in her termination from the hospital.

22           E     Unacceptable Blood Alcohol Level - 2006  
23                   By her own admission, on or about January 6, 2006, pursuant to a  
24 *Diversion* Program routine drug screening, Respondent tested positive for ethyl glucuronide  
25 (alcohol) at an unacceptable level.

26           F.     Termination From *Diversion* for Non-Compliance - 2006  
27                   On or about April 19, 2006, Respondent was terminated from the Board's  
28 *Diversion* Program for noncompliance with her *Diversion* contract. At time of termination, the

1 Program notified the Board that Respondent had been deemed a risk to public safety, due to "lack  
2 of internalized recovery" and based on "a high probability" that Respondent would immediately  
3 seek work which would allow opportunities for diversion of controlled substances.

4 **FIFTH CAUSE FOR DISCIPLINE**

5 **PARKVIEW COMMUNITY HOSPITAL AND MEDICAL CENTER**

6 **(Obtaining Controlled Substances by Fraud, Deceit, Misrepresentation or Subterfuge )**

7 23. Respondent's license is subject to disciplinary action under Business and  
8 Professions Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as  
9 defined in Business and Professions Code, section 2762, subdivisions (a) and (b), for violating  
10 Health and Safety Code sections 11170, 11171, and 11173, subdivisions (a) and/or (b) and/or (c)  
11 in that while on duty as a registered nurse in the Intensive Care Unit ("ICU") at Parkview  
12 Community Hospital and Medical Center in the city of San Bernardino, CA (hereinafter  
13 "Parkview"), approximately between December 12, 2007 and January 10, 2008, Respondent  
14 obtained, possessed, and/or furnished to herself controlled substances and dangerous drugs by  
15 use of fraud, deceit, misrepresentation or subterfuge, and/or concealment of material fact(s) as  
16 follows:

17 A. Pursuant to its routine review of Pyxis medication dispenser medication  
18 "override" transactions in ICU on or about January 10, 2008, Parkview investigators discovered  
19 irregularities involving Demerol 75mg on dates between December 12, 2007 and January 10,  
20 2008.

21 B. "Override" procedures allowed staff to download medications from  
22 Pyxis, per new or emergency physician's orders, without waiting for those orders to be processed  
23 by the hospital pharmacy. However, hospital policy required that such transactions be  
24 "witnessed" by a second employee, who assumed responsibility for verifying that a new or  
25 emergency physician's order had, in fact, been issued.

26 C. Investigators subsequently identified 55 doses of Demerol 75 mg which  
27 had been withdrawn from the Pyxis system as "override" transactions during the subject time  
28 period, for 12 different patients. There was no documented physician's order and no

1 documentation in patient records indicating any patient had received the withdrawn medication,  
2 for any of the 55 transactions.

3 D. Investigators suspected employee diversion due to the complete absence of  
4 physician's orders or patient records entries for the transactions, and because during the subject  
5 time period, Demerol was rarely prescribed for patients in ICU.

6 E. Investigators suspected that an employee was making withdrawals from  
7 the Pyxis system, using access codes of nurses who had not properly exited the system after a  
8 legitimate transaction.

9 F. Respondent's employment at Parkview was terminated on January 21,  
10 2008 when, pursuant to internal investigation, several unauthorized withdrawals were attributed  
11 to her.

12 E. Unauthorized withdrawals were attributed to Respondent based on the  
13 following facts:

14 1. Investigators identified Respondent as the only nurse who had  
15 worked on all dates when the irregular transactions occurred.

16 2. Respondent's Pyxis access code was entered as the nurse  
17 withdrawing the medication or the verifying "witness" for 27 of the 55 transactions.

18 3. On at least one instance (January 9, 2008 at 1550 hours) a  
19 transaction was made at the ICU Pyxis in the name of (and using the access code for) a  
20 nurse (L.O.) who was not physically present in ICU at the time - indicating that someone  
21 else had obtained and used her access number. Respondent's access code was entered as  
22 the "witness" for this transaction.

23 4. Nurse V.B. was asked to witness two Pyxis override transactions  
24 on January 10, 2008 at 0720 and 1015 hours by Respondent, and did so. Nurse V.B. was  
25 told by Respondent that she (Respondent) was withdrawing Ativan and Dilaudid. Pyxis  
26 records show drug transactions at the referenced date and times. However, Respondent  
27 was not signed into the system. Pyxis records show a different nurse's access code in use  
28 for the referenced transactions; and that Demerol 75 (not Ativan or Dilaudid) was

1 withdrawn both times.

2 **SIXTH CAUSE FOR DISCIPLINE**

3 **PARKVIEW COMMUNITY HOSPITAL AND MEDICAL CENTER**

4 **(Falsified Hospital Records)**

5 24. Respondent's license is subject to disciplinary action under Business and  
6 Professions Code section 2761, subdivision (a) and (d), on the grounds of unprofessional  
7 conduct, as defined in Business and Professions Code, section 2762, subdivision (e), for violating  
8 Health and Safety Code sections 11350, subdivision (a) and 11173, subdivisions (a) and (b), in  
9 that while employed as a registered nurse at Parkview Community Hospital and Medical Center  
10 in the city of San Bernardino, CA, on January 9, 2008 at approximately 1550 hours, and January  
11 10, 2008 at approximately 0720 and 1015 hours, Respondent falsified, made grossly incorrect or  
12 grossly inconsistent entries in hospital and patient records pertaining to controlled substances and  
13 dangerous drugs as more particularly described in paragraph 23 (E) above.

14 **OTHER MATTERS**

15 25. By her own admission, made to a Board investigator in April of 2007,  
16 Respondent was terminated from employment at POMONA VALLEY HOSPITAL in the city of  
17 Pomona, CA in or about August of 2006, due to an allegation that she stole money from a  
18 patient.

19 26. On or about March 26, 2002, an administrator at ST. BERNARDINE  
20 MEDICAL CENTER in San Bernardino, CA registered a 'do not send' complaint with a registry  
21 service that had placed Respondent at St Bernardine, due to his suspicion that Respondent had  
22 diverted a quantify of Demerol. Respondent wrote a letter dated April 4, 2002, strongly denying  
23 that she had ever abused drugs, and claiming that "my life has been turned upside down due to  
24 false accusations."

25 **PRAYER**

26 WHEREFORE, Complainant requests that a hearing be held on the matters herein  
27 alleged, and that following the hearing, the Board of Registered Nursing issue a decision:


28 1. Revoking or suspending Registered Nurse License 375784 issued to

Respondent MAGDA GONZALEZ a.k.a. MAGDA C. NERCISSANTZ a.k.a. MAGDALEN  
NERCISSANTZ a.k.a. MAGDALENA NERCISSANTZ a.k.a. MAGDALENA  
MANASSERIAN ;

2. Ordering Respondent MAGDA GONZALEZ a.k.a. MAGDA C.  
NERCISSANTZ a.k.a. MAGDALEN NERCISSANTZ a.k.a. MAGDALENA  
NERCISSANTZ a.k.a. MAGDALENA MANASSERIAN to pay the Board of Registered  
Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to  
Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 5/27/09

  
RUTH ANN TERRY, M.P.H., R.N.  
Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
Complainant

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